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# Resource-oriented therapeutic models in psychiatry – A conceptual review

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**Abstract**

*Background:* Like other medical specialties, psychiatry has traditionally sought to develop treatments targeted at ameliorating a deficit of the patient. However, there are also a number of different therapeutic models that focus on utilizing patients' personal and social resources, instead of ameliorating presumed deficits. A synopsis of such models might help to guide further research and improve therapeutic interventions.

*Aims:* To conduct a conceptual review of resource-oriented therapeutic models in psychiatry, in order to identify their shared characteristics.

*Method:* The literature was searched to identify a range of resource-oriented therapeutic models, particularly for patients with severe mental illnesses. Key texts for each model were analysed using a narrative approach to synthesize the concepts and their characteristics.

*Results:* Ten models were included: befriending; client-centred therapy; creative music therapy; open dialogue; peer support workers; positive psychotherapy; self-help groups; solution focused therapy; systemic family therapy; and therapeutic communities. Six types of resources were utilized: social relationships, patient's decision making ability, experiential knowledge, patient's individual strengths, recreational activities, and self-actualising tendencies. Social relationships are a key resource in all the models, including relationships with professionals, peers, friends and family. Two relationship dimensions – reciprocity and expertise – differed across the models.

*Conclusion:* The review suggests that a range of different therapeutic models in psychiatry address resources rather than deficits. In various ways, they all utilise social relationships to

induce therapeutic change. A better understanding of how social relationships impact on mental health may inform the development and application of resource-oriented approaches.

*Declaration of interest:* None

*Key words*: Resources, therapeutic models, relationships, severe mental illness, psychiatry

## Introduction

Medical diseases are commonly characterised by a deficit, and treatments are designed to target – directly or indirectly – that deficit so that the patient is cured or at least not hindered by the deficit anymore. The history of psychiatry has been dominated by a similar deficit focus.[1,2] Treatments have been developed to remove or ameliorate the presumed deficit, even if assumptions on the specific nature of the deficits may have often been rather speculative. Such a deficit focus applies to models of pharmacological treatments as well as psychotherapeutic ones, such as psychoanalysis or cognitive behaviour therapy that aim to solve an underlying conflict or to change maladaptive thinking and behaviours.

This focus on deficits has a number of limitations.[2-4] For example, it may strengthen a negative image of the patient[4] and reduce their sense of control, leaving them passive recipients of expert care.[2] Arguably more important is that the deficit focus in psychiatric research has produced, at best, limited progress in developing more effective treatments since the 1980s.[5,6] New perspectives might help to advance treatments and develop novel and more effective ones.

Not all therapeutic models in psychiatry however have been developed to target deficits. Instead, a number of very different models of therapeutic interventions aim to tap into the strengths of patients and utilize their positive personal and social resources. Such models can

be considered as ‘resource-oriented’. Eventually, they may indirectly affect the symptoms of a defined disease, but their primary target is patients’ resources, rather than deficits.

Resource-oriented models have been described by a large body of literature and have been more or less widely used in practice. In the literature, they are usually treated separately without considering their shared resource-orientation. A synoptic view of resource-oriented models with an analysis of their commonalities and differences might help to specify how resources may be used in psychiatric treatment, guide further research on effective ways of using resources therapeutically and support the development of more beneficial interventions in the future.

Against this background, we conducted a conceptual review of resource-oriented therapeutic models in psychiatry. The review focused on therapeutic models for patients with severe mental illnesses, as the traditional core group of patients in psychiatry, without using diagnostic categories. Conventional diagnostic categories, sometimes linked to the idea of disorder specific treatments, may suggest a more deficit-oriented understanding of diseases which would have been inconsistent with the aim of the review.

Our specific objectives were to compile a non-exhaustive list of distinct therapeutic models in psychiatry that can be seen as resource-oriented, and identify their key characteristics.

## Methodology

### *Review approach*

A systematic search with fixed search terms was of limited use as the resource-orientation of such models has not necessarily been explicitly addressed in the literature, and the sources of such information are often disparate. Instead, we followed the recommendations for

conceptual reviews by Lilford et al.[7] to gain a diverse understanding of resource-oriented models. This included:

- Searching widely using disparate databases and sources, i.e. journal articles, textbooks and web-based sources within a variety of disciplines, without attempting an exhaustive review of all the literature.

- Making sure that the review is informed by different perspectives. The review team was multi-disciplinary and included two academic/clinical psychiatrists (SP, who is also a psychologist, and DG), an academic/clinical psychologist (MS) and a research psychologist (SO). They were trained and qualified in three different countries (Germany, Italy and United Kingdom), represent different age groups and possess different areas of expertise. Moreover, the emerging findings were regularly discussed in a team of about 20 researchers and clinicians in East London.

- Allowing some overlap in the various stages of the review process so that the precise nature and scope of the review can be clarified.

*Data collection*

We did not aim to compile an exhaustive list of all models that might be seen as resource-oriented, but to compile a diverse sample of distinct models. We started by identifying a range of models from the literature known to the authors and complemented this with a general search of PsychINFO, MEDLINE and Google Scholar (any date) using keywords such as “resources” or “resource-oriented” or “resource-based” OR “strengths” or “strength-based” or “strengths-oriented” AND “therapy” or “psychotherapy” or “interventions”. Reference lists of relevant papers were also screened. The inclusion criteria for the models

were: (a) the original model focused primarily on utilising patients' resources rather than ameliorating a deficit; (b) implemented in practice with individuals with severe mental illness; (c) explicitly described in the literature (as a defined model) and established in practice in more than one service (so as to exclude descriptions of models that were either never or only experimentally implemented); and (d) sufficiently distinct from each other to allow for the analysis of aspects across different models. As we were interested in conceptual characteristics, we did not consider evidence for effectiveness.

For each of the identified models, we then conducted a non-systematic search of PsychINFO, MEDLINE and Google Scholar using the names of the models as keywords (e.g. "client-centred therapy" OR "solution-focused therapy"). Results and relevant reference lists were screened for key texts describing each model. Such key texts included the original description of the model, commonly cited standard publications, text books, and guidelines from professional bodies. Again we did not aim to compile an exhaustive list of texts for each model, but to gain a sufficient conceptual understanding of each model for the purpose of the review.

*Data analysis*

We used a two-stage narrative synthesis approach modified from the guidelines by Popay et al.[8] In line with Lilford et al.[7] these stages had some overlap. Continuous discussion among the multidisciplinary team, critical reflection, and feedback from other researchers and clinicians were used throughout.

In the first stage, an initial framework of criteria was developed with which to explore the commonalities and differences. Key texts were read and a list of criteria was generated to

characterise the resources used in the models. This was achieved through an inductive process, whereby understanding the descriptions of the models in the key texts led to the formulation of the criteria, and through continuous discussion among the research team to refine the criteria in an iterative process.

In the second stage, key texts were re-read and each model was characterised based on the framework of criteria using tabulation. The extent to which each model met these criteria was based on the explicit descriptions of the models in the key texts. Commonalities and differences were then analysed and the focus of the review decided accordingly. These characteristics were continuously discussed among the research team in an iterative process.

## Results

### Resource-oriented models of therapeutic intervention

We identified ten distinct resource-oriented therapeutic models to be included in the further analysis:

*Befriending*

Befriending schemes involve the regular provision of a supportive relationship through one-to-one companionship, by matching volunteers with patients who engage in shared social and recreational activities.[9-12]

*Client-centred therapy*

Client-centred therapy assumes that all people have a self-actualising tendency. It facilitates this self-determination toward optimal functioning through helpful therapist behaviour with empathy, congruence and unconditional regard.[13-17]

*Creative music therapy*

The Nordoff-Robbins model of music therapy uses music creation and the meaningful interactions within it to encourage the patients' personal growth, expressive skills and their ability to relate to others.[18-22]

*Open dialogue*

Open dialogue treats patients within their own personal support systems. This is achieved by involving patients, their social network and healthcare professionals in joint treatment meetings and promoting a dialogue to help them understand the patients' experiences.[23-25]

*Peer support workers*

Peer support workers are individuals with a history of mental illness who are employed in the provision of care of others with similar problems.[26,27]

*Positive psychotherapy*

Positive psychotherapy uses a number of exercises to build happiness by encouraging positive attitudes, cognitions and behaviours.[28]

*Self-help groups*

In self-help groups or mutual support groups people with shared problems meet regularly to support one another.[29-31]

*Solution focused therapy*

Solution focused therapy helps patients identify exceptions to the problem and then find possible solutions that work independently of the cause of the problem.[32-34]

*Systemic family therapy*

Systemic family therapy can include different structural and strategic models.[35-38] They all treat patients within the context of their family, focusing on interactions or boundaries to mobilize the resources of the family.

*Therapeutic communities*

Therapeutic communities aim to create a community within an institution. They provide a "living-learning situation", in which everything that occurs between staff and patients can be applied to life outside. [39-42]

**Resource-oriented themes**

The two-stage synthesis identified six themes describing different types of resources that are explicitly utilized and developed in the models. The themes have some overlap, but still represent different criteria to characterise the models. Table 1 summarises their distribution across the different models.

**Insert Table 1 about here**

*Social relationships*

All ten models utilize the patients' social relationships in one way or another. As a result, this later became the focus of further analyses in the review.

*Patient's decision making ability*

Several models rely on the patient's decision making ability. In client-centred therapy the therapist takes a non-directive approach, allowing the patient to make their own decisions.[13-17] Similarly, in solution focused therapy the patient is seen as the expert who knows what solutions would work best. The therapist asks the right questions to guide the patient in identifying these solutions.[32-34] Creative music therapy also allows patients to have a high level of freedom in deciding where to go next with the session and in what way they wish to contribute to the session.[18-22] In the open dialogue model the patient's opinion on treatment decisions is very important, even if this means holding back on medication or hospitalization.[24,25] Finally, in therapeutic communities shared decision-making among both patients and staff is an important principle.[39,40] These models all show confidence that the patients know best and utilize their ability to make decisions.

*Experiential knowledge*

Some of these models utilize the experience and knowledge of the patient. In solution focused therapy the patient is encouraged to think of what has worked in the past to identify potential solutions.[32-34] In therapeutic communities, it is hoped that the experiences of the patients within the community provide skills and knowledge that can be applied to life outside of the institution.[39-41] Similarly, in positive psychotherapy[28] the "three good blessings" exercise requires the patient to write down three good things that have happened and why. Another exercise also involves "savouring" something that patients normally rush in

everyday life and writing down what they did differently and how it felt. These exercises can encourage the use of a patients' experiential knowledge. Self-help groups and peer support workers, on the other hand, utilize the experience of patients in helping others who are going through a similar situation.[26,27,29,31] Experiential knowledge is, therefore, a resource that can be drawn upon to either directly help the individual themselves or to help others with a shared problem.

*Patient's individual strengths*

Some of these models also use the individual strengths of patients, i.e. what it is that they are good at. In positive psychotherapy this is achieved through the "signature strengths" exercise where patients write down their top five strengths and think of ways that they could use these within everyday life.[28] In solution focused therapy the therapist helps patients to explore the things that work. This may involve the identification of strengths that could be drawn upon as a solution.[32-34] Finally, in creative music therapy the patients' strengths are used to structure the intervention itself. For example, if patients are good at singing, writing music, playing an instrument, then this should be utilized in the session.[18-22] The patients' individual strengths are a key resource that can be drawn upon to both achieve the aims of an intervention and to guide the intervention itself.

*Recreational activities*

Three of the models use recreational activities. Many self-help groups provide an opportunity for patients to engage in recreational and social activities together.[29] In creative music therapy, patients are given the opportunity to play instruments, write music, or sing.[18-22] A key aspect of befriending involves the befriender and befriendee taking part in various recreational activities together, such as going to the cinema, playing sports and socialising.[9-12]

These recreational activities can be used to build confidence and meaningful contact with others.

*Self-actualising/self-correcting tendencies*

Finally, two of the models also share the assumption that individuals or groups have natural positive tendencies that can be utilized. In client-centred therapy it is assumed that all humans have a self-actualising tendency, a drive to be the best they can be.[13,15] It taps into this drive within individuals to grow and simply provides the right environment for such growth to occur. Similarly, systemic family therapy utilizes the family's natural homeostatic mechanisms and self-actualising tendency. For example, in structural family therapy the therapist might challenge the balance of the system allowing it to correct itself favourably.[35] Client-centred therapy and systemic family therapy have confidence in these natural positive tendencies and utilize them as a resource.

**Types of relationships**

As all ten resource-oriented models utilize relationships, we conducted further analyses to identify the types (with whom) and nature (how) of the relationships used. Four types of relationships are used: with (i) professionals, (ii) peers, (iii) friends, and (iv) family. Table 2 shows which types of relationships are used in the different models.

**Insert Table 2 about here**

*Professionals*

Relationships between professionals and patients are a component explicitly used across the models. In client-centred therapy, the patient's perception of empathy and unconditional positive regard from the therapist and the genuine contact between two individuals are central principles.[13-17] Although an empathic therapeutic relationship can be seen as important in any psychological intervention, the client-centred model explicitly details it as the core element. Similarly, the therapeutic alliance and use of a solution-focused conversation between therapist and patient have been identified as specific active ingredients in solution-focused therapy.[34] The professional-patient relationship is also central in therapeutic communities, where patients and staff are encouraged to take part in various shared everyday activities as learning experiences.[41,42] Structured meetings also provide an opportunity to discuss any issues that may be affecting this community life to strengthen the relationships.[42] Creative music therapy[18-22] uses musical activities to engage patients in meaningful contact with a therapist, utilizing non-verbal means for patients who may otherwise find it difficult to engage in such relationships. In open dialogue the principle of psychological continuity is important, in which the same professionals are involved in the patient's treatment meetings throughout to stay connected with the patient.[24,25]

*Peers*

Some of the models also utilize the patient's relationships with peers. In therapeutic communities this is similar to how relationships with professionals are utilized, i.e. through joint activities and structured meetings.[41,42] Such relationships can be used as learning experiences to apply to relationships outside the institution. Self-help groups and peer support workers provide an opportunity for patients to gain social support from peers who have been

through similar experiences and can offer additional empathy and understanding which a professional without such experience cannot.[26,27,31] Finally, creative music therapy can provide meaningful contact with peers through non-verbal interactions in group sessions,[18-22] which may benefit those patients who are unable to engage in social relationships through other means.

*Friends*

The models also use friendships. In positive psychotherapy there are several therapeutic exercises that can improve a patient's friendships.[25] "Gratitude visits" stipulate the patients to thank somebody to whom they are grateful. "Active-constructive responding" involves reacting in a visibly positive and enthusiastic way to good news from someone else once a day. Such exercises encourage patients to appreciate their friendships and may strengthen them. Befriending schemes provide patients with new friendships, offering additional support and fostering their social skills.[9-12] Finally, open dialogue mobilizes a patient's wider social network from the start of their treatment. It attempts to create a dialogue to help significant members of the patient's social network, including friends, better understand the patient's experiences.[23-25]

*Family*

The models also make use of the patient's family relationships. Systemic family therapy aims to improve the interactions and clarify the boundaries in the family system.[35-38] This can mobilize the resources of the family to support a patient and build up resilience. Similarly, solution-focused therapy originally grew from family therapy to mobilize the resources of the family.[43] Positive psychotherapy may utilize the family in the same way as it utilizes friendships, through "gratitude visits" and "active-constructive responding".[28] The open

dialogue approach can also utilize the family in the same way as it does friendships, through creating a dialogue between the patient and family members.[23-25]

## The nature of relationships

Whereas all the models utilize social relationships, their nature may vary in terms of the reciprocity of the helping relationship and the reliance of expertise.

### *Reciprocity*

Some of the models suggest a reciprocal helping relationship between a therapeutic provider and the patient. In therapeutic communities, both patients and staff should be seen as equal in the community, learning from one another and making decisions together.[39-42] Similarly, self-help groups are usually run by the members of the groups themselves with everyone bringing their own support for one another.[26] Befriending can also be seen as a reciprocal relationship in that both patient and befriender are there to create and maintain a friendship, not a therapeutic relationship.[9-12] Open dialogue also facilitates reciprocal relationships by promoting a dialogue to facilitate change in the whole family[23-25] and viewing patients as partners in therapy, rather than objects of therapy.[24] On the other hand, client-centred therapy, systemic family therapy, solution focused therapy, creative music therapy, positive psychotherapy and peer support workers all suggest a unidirectional relationship with a therapeutic provider from whom a patient receives help. Peer support workers, however, may suggest a more reciprocal relationship than the others.[26]

*Expertise*

There are some differences between the models regarding who is seen as the expert. In client-centred therapy,[13-17] solution-focused therapy,[32-34] positive psychotherapy[28] and open dialogue[23-25] the patient can be seen as the expert who knows best. The therapist taps into this expertise by asking relevant questions or providing necessary exercises. For self-help groups[29-31] and peer support workers,[26,27] it is the peers who have at least some of the relevant expertise. Their experience is relied upon in supporting the patient. In therapeutic communities everyone can be seen as the expert and everyone is there to learn from each other.[39-42] Patients are commonly seen as the experts, whether it be the patients themselves or peers. The only arguable exception to this is systemic family therapy, where the therapist can be seen as the expert who is there to influence the family system.[35-38]

## Discussion

*Main findings*

Using a narrative approach we have synthesized conceptual characteristics of distinct resource-oriented therapeutic models for patients with severe mental illnesses and identified six resources that are utilized in such models: social relationships, patient's decision making ability, experiential knowledge, patient's individual strengths, recreational activities, and self-actualising/-correcting tendencies. Social relationships, especially, appear to be central in all the models. Further analysis identified four types of social relationships that may be used, i.e. with professionals, peers, friends and family. The nature of the relationships suggests a unidirectional helping relationship for most of the models, although some appear to be more

reciprocal. Finally, the majority of the models suggest the expertise lies with the patients, either the patient in question or peers who have had similar experiences.

*Social relationships*

Although the review included very different models, all of them share one core characteristic, i.e. the idea to utilize social relationships for bringing about change and helping the patient. Relationships are also seen as important in other therapeutic models that do not primarily focus on resources[44,45] and have been suggested as crucial for the recovery process.[46-49] However, people with severe mental illnesses have very few close relationships to utilize.[50-54] The therapeutic context may therefore be an approach to help the patient learn to establish and maintain beneficial relationships.

Yet, it has been suggested that some relationships may also have a negative impact on a patient's recovery.[47,55,56] Thus, the therapeutic task is not only to increase the number of social relationships, but to help the patient to shape them so that they are beneficial. The models in this review vary in their explicit assumptions about how exactly relationships are to be used and be beneficial to the patient, but two potentially important aspects were identified. Some, but not all, the models provide a sense of reciprocity and expertise within the relationships. This may strengthen a person's sense of personal agency and efficacy, with a positive impact on their recovery.[47,48,53,57]

This importance of social relationships in psychiatric therapeutic models parallels similar trends towards emphasising relationships in other fields, including teacher-student relationships in education,[58] caregiver-child relationships in healthy child development,[59] and helping relationships in social work[60] and physical health.[61]

*Strengths and limitations*

Although we searched widely and included different perspectives, the reliance on expertise within the research team may have made the review and analysis selective. The findings represent the interpretation of the research team, may be influenced by their belief in the importance of a social dimension of mental health care,[6] and do not constitute an exhaustive understanding of resource-oriented models in psychiatry. The characterisation of some models may also be seen as simplified and debatable. Finally, we focused only on resource orientation without exploring how such an approach may be integrated with a deficit orientation.

However, the flexible and dynamic approach has enabled us to gain a diverse understanding of the disparate literature, to conceptualise resource-oriented therapeutic models, and to arrive at criteria for characterising key aspects.

*Conclusion*

A number of therapeutic models in psychiatry do not target a deficit of the patients, but focus on the patients' positive resources. They vary, and are often rather vague, in the extent to which they specify which resources are used, how exactly they are mobilised, and what precisely their beneficial effect is. More conceptual work on this might benefit from considering several models rather than analysing each one in isolation.

All the models utilize social relationships, although the type and nature of the relationships vary. A better understanding of how social relationships impact on patients' mental health might help to advance such models and, possibly, to develop new ones. This may require more specific theories about the helpful factors across social relationships and how they can be used in different therapeutic contexts.[44,62] The identification of overarching aspects of relationships – such as reciprocity and expertise – may provide a framework for evaluating how different forms of relationships facilitate change and reduce mental distress.

In treatment studies, relationships and interactions should be assessed more systematically to provide evidence on helpful processes, and underpin the advancement of existing models and the development of novel ones. Further empirical research on social relationships is badly needed in psychiatry, and may inform the development of new therapeutic models in the future.

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**Contributions**

Conception and design by SP. All authors contributed to analysis and interpretation. The article was drafted by SP and SO, and revised critically by all authors. All authors gave final approval to be published.

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## Tables and figures

**Table 1: Resources explicitly utilized in the therapeutic models**

| | Social relationships | Patient's decision-making ability | Experiential knowledge | Patient's individual strengths | Recreational activities | Self-actualising/ self-correcting tendencies |
|---|---|---|---|---|---|---|
| Befriending | ✓ | | | | ✓ | |
| Client-centred therapy | ✓ | ✓ | | | | ✓ |
| Creative music therapy | ✓ | ✓ | | ✓ | ✓ | |
| Open dialogue | ✓ | ✓ | | | | |
| Peer support workers | ✓ | | ✓ | | | |
| Positive psychotherapy | ✓ | | ✓ | ✓ | | |
| Self-help groups | ✓ | | ✓ | | ✓ | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Solution-focused therapy | ✓ | ✓ | ✓ | ✓ | | | |
| Systemic family therapy | ✓ | | | | | | ✓ |
| Therapeutic communities | ✓ | ✓ | ✓ | | | | |

**Table 2: Types of social relationships explicitly utilized in the therapeutic models**

| | Professionals | Peers | Friends | Family |
|---|---|---|---|---|
| Befriending | | | ✓ | |
| Client-centred therapy | ✓ | | | |
| Creative music therapy | ✓ | ✓ | | |
| Open dialogue | ✓ | | ✓ | ✓ |
| Peer support workers | | ✓ | | |
| Positive psychotherapy | | | ✓ | ✓ |
| Self-help groups | | ✓ | | |
| Solution-focused therapy | ✓ | | | ✓ |
| Systemic family therapy | | | | ✓ |
| Therapeutic communities | ✓ | ✓ | | |